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# SYMPOSIUM ON HEALTH AND DEVELOPMENT*

## Introduction

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HEALTH AND DEVELOPMENT represents a distillate and a departure. Reflected in the theme and choice of topics in this symposium are the experiences derived from Calcutta epidemics, from an Egyptian fever hospital where a simple but fatal syndrome–infant diarrhea–accounts for half the pediatric deaths, from the remote African bush where the game of survival is played out with the rarest participation of trained medical personnel, and from the crises of a Nicaraguan earthquake where the survivors of the disaster may well have envied the dead.

Few who have not experienced the burden of disease and poverty in the Third World can even comprehend its scope or understand

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its impact on every form of human endeavor. How should one express in living words the anguish implied in a cold statistic such as an infant death rate of 350 to 400 per 1,000 live births in almost any developing land versus an average 12 per 1,000 in the United States? How does one capture for those who have not seen and do not know them the constant pangs of hunger, the dwindling strength of a parasitized parent who wants to work, the pain of unnecessary illness, the frustrations of ignorance, and the unacceptable but almost inevitable loss of every human dream and desire at an early age when individual pleasure and productivity as well as national development should be at the maximum?

The physician has a privileged position from which to view this scene, but alone he is almost impotent to effect any change. For too long medical professionals have spoken only to one another—documenting the toll of disease, studying its causes and victims, calling upon anyone and everyone to listen to their advice. They have failed, however, to move beyond the traditional limitations of the profession, failed to realize that merely convincing—or is it conversing with?—one another has not altered economic policies or significantly influenced political will, and it is in these arenas that the critical decisions which determine the extent, or even existence, of health programs are made most frequently. Too rarely have competent, respected health experts been willing to venture from their safe havens into the turbulent councils where government priorities are established and financial allocations are set. Those best qualified have made too small a contribution to these councils in regard to the human resource, the human potential for, and the impact on people from developmental projects. Yet all give lip service to these as the goals of modernization and "progress."

There is a paucity of professional courage in this area, a reluctance to abandon the rigid, privileged positions of the consultant for the new but obviously necessary challenges of political decision-making; there is a poverty of medical initiative, innovation, and even thought. If there has been a sense of outrage at the human condition in many parts of the world those who should be most able to express this have been either unable or unwilling in comprehensible terms which can alter the opinions and actions of the decision-makers noted above to articulate the harsh realities of life as they exist for the majority of mankind.

For too long we who deal with and know most intimately the one unique resource of the Third World—the human being—have allowed

our projects to remain dreams and our priorities to be words. No international health worker is blind to the obvious interdependence of health, education, agriculture, engineering, and so many other disciplines, but need we wait for simultaneous progress in all these fields before any change is made? That approach seems, at best, an exercise in futility and perverse sophistry and, at worst, an admission of predictable failure, an excuse for no new action, and a defense of the deplorable present status of international health.

Any perceptive worker in this field realizes that the challenges of tropical medicine today are not merely a repetition of the great era of defining new parasites and life cycles, of discovering effective modes of individual therapy, or even of mass methods for the control of infectious diseases. Instead, he must deal with the reality that health services reach less than 10% of the population in most developing countries, that the world population is expanding faster than its health services, that malnutrition is the rule for two thirds of all mankind, and that in the developed nations there seems to be neither the political will, the money, nor the technology to alter this course.

There has been, in fact, a growing—if long overdue—appreciation that transferring Western medical technology, systems, and approaches to developing lands may not only be a great waste of funds, talent, and equipment, but is often an absolute detriment to an effective and appropriate health-delivery service. In Somalia, for example, I have noted the lasting burden of an inappropriate health "gift" when that poor East African nation attained her independence.[1] The European Economic Community (EEC) presented to that nation of nomads an ultramodern hospital—a building that belonged in Brussels. The structure almost reduced the nation's health budget to the breaking point while also centralizing almost all medical services in the capital city. The hospital may have served the wealthy few, but the nomadic masses suffered more neglect. The challenge of redefining the education and role of the physician and the auxiliary health worker has been considered in an earlier program in this series.[2]

New challenges exist not only in health but in all areas of development. At one time it was de rigueur to define individual and national development in income per capita and in levels of gross national product (GNP). In the field of tropical medicine one could even calculate a "malaria tax," which referred to the extra cost of a product due to

inefficiency and illness caused by that disease. Gradually, however, these terms became mere words to the newly independent nations struggling to define their own identities. Once again lip service was not enough.

Many of these new nations had virtually one resource only—their citizenry. Political and economic leaders had to grapple with the less specific but more real human factors of life itself, health, satisfaction, pride, personal and national achievement, and a myriad of other investments and dividends that defied standard classifications. Nations began to recognize that modernization was not necessarily synonymous with development and that the most desired so-called improvements were often accompanied by unexpected, disastrous complications.

I have cited this *Symposium on Health and Development* as a personal and professional distillate and departure. My own work has evolved from the study of distinct tropical infections and the use of mass-screening techniques to a wider consideration of medicine as a vehicle for international cooperation and understanding. The present work extends that thesis while making more specific the necessity for involving the politician, diplomat, and financier if improvement in health care is to be our true goal.

We must no longer merely give lip service to independence and nationalism, but must consider their adverse effects as proper matters for our consideration if we really hope to make effective changes. Can we continue, in the handwashing fashion of Pontius Pilate, to give lip service to the ideals of the World Health Organization (WHO) without facing the hard fact that its total annual expenditure is less than one tenth of New York City's health budget, that the WHO is only an advisory body that does not claim operational activities in most health areas in the tropics, and that the WHO is an organization whose member states have been known to deny the very presence of cholera for fear of losing tourist income. This should not be misinterpreted as unfair criticism of the WHO—the organization does serve a number of unique functions—but to cite the danger of continuing to indulge in vacuous compliments as an alternative to facing facts and dealing realistically with them.

We must deal with the ethical problems of development and recognize political and economic priorities if an improvement in health is to be our real goal. If we remain within the confines of academia or take refuge from reality behind the privileges of our profession we cannot

hope—and do not deserve—to have a significant impact on the future health of our species.

This is the 10th in a series of symposia[2-4] inaugurated shortly after I returned from residence in the tropics. There have been six detailed dissertations on specific disease entities, an historical review, an examination of health education for the tropics, and a philosophic program, *The Untapped Resource*,[3] which considers the relations between medicine and diplomacy. That volume was translated into a proposed statute in the United States Congress, the International Health Agency Act of 1971, and provided the basis for extensive hearings in both the Senate and House of Representatives on the role of the United States in world health. The hearings did not reveal a flattering picture, and the bill did not pass into law, but at least senators and representatives were informed, most for the first time; there had been no Congressional hearings on international health in more than 15 years and the declining medical programs of the Agency of International Development (AID) were virtually unknown by those who annually allocated the funds.

The possibility of moving a philosophy of medicine into Congressional hearings and of drawing upon the goodwill that is available to our profession (if we are willing to venture forth with sound ideas) further stimulated the present program.

There is great benefit in having the secretary-general of the United Nations (UN) open a symposium on health and development in the world. But Kurt Waldheim's contribution is more than the expected token benediction; it forcefully cites the ideals of the UN and the WHO while clearly noting lapses in political will and the fragility of international cooperative efforts.

The necessity for political understanding and will to implement any significant health program in a developing country is discussed by Sr. Eduardo Frei, the former president of Chile. Widely respected as among the most thoughtful and articulate government leaders in Latin America in this century, Sr. Frei cites the priority that health care may assume among the competing goals of a developing nation, but notes the realities that often determine the final balance of an inadequate economy.

In a poetic paper Lord Ritchie-Calder discusses the ethical and economic implications of health-development projects. Few men have had so vast an experience in interpreting for the public the advances of science and technology as this Scottish Lord whose career has taken

him from the political front lines of the Labour Party through journalistic endeavors on five continents to several academic appointments as a professor of international relations and presently to the philosophic post of senior fellow at the Center for Democratic Studies in California.

For almost 20 years Professor W. H. Russell Lumsden was director of the Sleeping Sickness Services in East Africa. While making major contributions to the science of tropical medicine, he has had an almost unique vantage point from which to observe the effects of nationhood on the diseases of a region where insect vectors do not recognize political borders. He was the director of research programs under the relatively uncomplicated Colonial Medical Service during the period of transition and under the new African leadership. He has had extensive experience with the problems of maintaining a health and research service during periods when expatriated personnel did not have the security of a home-employment base and before adequate numbers of indigenous medical leaders existed. His paper is solid, reflective, and realistic, yet optimistic.

The public record of the Hon. Hugh L. Carey* is ennobled by a long-standing and effective commitment to the improvement of health care. Throughout his long career in the House of Representatives Mr. Carey provided critical political leadership in this country for global medicine and, almost alone, focused attention on this country's declining role in what he called "the one war we can win," the worldwide battle against disease. He introduced the International Health Agency Act of 1971 in Congress. His knowledgeable and persuasive paper demonstrates the understanding, encouragement, and conviction of a perceptive political person. He embodies the finest of that critical political facet too long ignored—indeed almost absent—from previous international health conferences.

The interrelations of host, infecting agent, and environment are considered in the presentation of Professor Herbert M. Gilles. His own epidemiologic studies in Africa demonstrate clearly that one cannot be comforted by the facade of modern medical centers, for far too frequently the expected beneficial effects on health statistics prove illusory if not franky deceptive. Certainly they often do not extend far from the building itself. The emergence of new patterns of disease and unrecognized health challenges from so-called developmental programs

*Now governor of New York State.

have formed the substance of many of Professor Gilles' well-known studies in Africa. He emphasizes the complexity of medicine in the developing world and the importance of considering social and economic factors in interpreting the significance and spread of disease, rather than merely establishing the incidence of infection, defining etiologic agents, or measuring the resistance of a host.

Research in tropical medicine has been justified for many years in highly industrialized and developed nations on the premises that these diseases pose a military threat to our armed forces, that they may afflict the small percentage of our citizens who travel through the tropics, or that they may become epidemic once again within our own borders. Alternatively, such research is defended on the basis that the more fortunate few of the world have a moral obligation to assist the disadvantaged many. Without denying the validity of any of these premises, it has long been my belief that research in tropical medicine can be readily justified—and should be financially supported—because the knowledge accrued from studying exotic infections so frequently has a direct bearing on our understanding of common ailments.

One can, for example, think in terms of that most exotic infection, kuru, which is transmitted by cannibalism in the mountains of New Guinea. It is unlikely that such open cannibalism will flourish in the United States, and one might well question the allocations of diminishing research funds to the study of such a syndrome. However, the clear relation of kuru to multiple sclerosis has changed that thinking, and the investigation of many latent, slow viral infections has been elucidated by studies begun in the mountains of New Guinea. The entire field of cancer research has been greatly stimulated by the detection of an exotic African lymphoma; the epidemiologic and therapeutic implications of these studies are profound. Dr. Joseph H. Burchenal, a world authority on the chemotherapy of cancer, reviews his own and other studies on Burkitt's lymphoma, first described in East Africa, and now recognized as but one of the curable forms in a broad mosaic of disease called cancer that is international in distribution and multifaceted in presentation and—partially because of observations made in rural Africa—no longer sounds the same uniformly ominous note for its victims.

In the past decade almost all emerging nations have carefully scrutinized the role of international cartels in their economies; despite many

failures to wed the developed and developing lands, there have been far more successful instances where private investments from capitalistic societies have been able to flourish, even under highly socialistic or rigidly totalitarian regimes. Few men have as successfully developed this bridge of mutual benefit as Mr. G. A. Costanzo, vice chairman of First National City Bank. With a background that includes determining fiscal policies for our State Department, senior positions in the World Bank, and a professorship in economics, Mr. Costanzo now directs the largest American banking firm overseas.

He deals daily with the reality of global monetary interdependence and the necessity of wedding the profit motive of private investment with the goals of a new nation's growth. He has considered the impact of health on economic productivity, and bluntly notes that the major funds for health services in developing countries must emanate from within those lands. Whether one agrees with this philosophy or not, we in the medical field must learn to deal with such facts, plan realistically within such limits, and increasingly involve such financiers in every aspect and stage of international health programs if our projects are to have lasting effect.

Medicine is a noble profession with a long and rich heritage of individual service. At the international level, however, it can no longer function effectively as an isolated discipline and it certainly cannot be viewed as an exercise in charity. It is one of the few common grounds on which those interested in world peace must base their efforts and focus their energies. As was contended in *The Untapped Resource*,[3] medicine, almost uniquely, is the cement of the global community and must be strengthened by politicians, diplomats, economists, and philosophers as well as physicians, if there ever is to be both health and development in this world.

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